

Health Insurance 101 and Autism

1. What types of health insurance coverage is available?

Generally, there are two types of health insurance: public health insurance (like Medicaid, Medicare, and CHIP) and private health insurance. Most people have some form of private health insurance, whether they purchase it through a marketplace or get it from their employer.

2. What is on exchange private health insurance?

On-exchange private health insurance policies are plans that are sold on government-run exchanges, like a state exchange or Healthcare.gov, the federal exchange. On-exchange plans must cover the ten essential benefits, plus any additional services that are mandated by your state legislature. Additionally, any insurer that wants to participate in a government-run exchange must offer a plan at every metal tier. On-exchange federal plans are the only plans for which premium tax credits and cost-sharing reductions (i.e., government subsidies for qualifying applicants) are available.

3. What is Off-exchange private health insurance?

Off-exchange private health insurance policies are plans that are sold either directly by the health insurance company, through a third-party broker, or a privately-run health insurance marketplace. Off-exchange plans must cover the ten essential benefits and follow other rules dictated by the Affordable Care Act - meaning you don't have to worry about any loopholes or 'gotchas' on off-exchange plans. The caveat with off-exchange plans is that you cannot apply any subsidies (e.g., the premium tax credit or cost-sharing reductions) to these plans. Providing an off-exchange plan may allow an insurer more flexibility. For example, because they don't have to offer a plan at every metal tier, insurers can offer just one type of health insurance plan and off-exchange plans give you more options at potentially lower price points.

4. What is Employer-provided health insurance?

Employer-provided health insurance plans, also called group plans, are private plans purchased and managed by your employer. Employer-provided plans need to follow the same rules as other private insurance plans and cover the ten essential benefits. If you're eligible for an employer-provided plan, you do not need to purchase additional coverage through the marketplace. Talk to your human resources department for more specific information about your plan.

5. What is Short-term health insurance?

Short-term health insurance plans provide limited health care coverage for a temporary gap in coverage. Since October 2018, federal rules have allowed short-term health plans to offer coverage for up to 12 months at a time, and made it possible for insurers to renew the coverage for up to 36 months. This plan would be beneficial to individuals looking for a new job or their new job has a waiting period before health insurance coverage kicks in. Short term

medical insurance typically provides some level of coverage for: preventive care, doctor visits, urgent care, and emergency care. There may also be coverage for prescriptions. Some plans also offer cost savings for seeing in-network providers. For example, a 29 year old woman making \$43,000 per year would pay approximately \$3,000 per year for a bronze-level ACA plan. For less than \$2,000 per year she can purchase a 12-month Short Term Health Insurance plan with a smaller deductible (\$5,000 v. \$7,900) and save over \$1,000 per year. Many large health insurers offer short-term options. Be aware, however, that short-term health insurance may have limits that regular health insurance does not have (e.g., caps on annual benefits paid). However, for stopgap coverage, these plans are a good option.

6. What is Medicare?

Medicare is a federal health insurance program for Americans above the age of 65. Anyone above the age of 65 can buy health insurance, regardless of their income level. There are four parts to Medicare that cover different healthcare services: Part A and Part B are considered Original Medicare, which is managed by the federal government. People can see any doctor that accepts Medicare and the government pays a portion of the cost. Parts C and D are paid for by the program participant.

- Medicare Part A covers inpatient care in a hospital or skilled nursing facility, although not custodial or long-term care. Part A also helps pay for hospice care and some home health care. Medicare Part A has a deductible (\$1,364 in 2019) and coinsurance, which means patients pay a portion of the bill.
- Medicare Part B covers doctor visits and other medically necessary services and supplies. That includes preventive services or health care to prevent illness, as well as ambulance services, durable medical equipment, mental health coverage and a few types of outpatient prescription drugs. You pay a premium each month for Part B, if you don't sign up for Medicare Part B at 65 and later decide you need it, you'll likely pay a penalty of 10% of the premium for each 12-month period that you delayed. You will pay this penalty for life, basically, since few people drop Medicare Part B once they have it.
- Medicare Advantage, also known as Medicare Part C, is a type of health plan offered by private insurance companies that provides the benefits of Parts A and Part B and often Part D (prescription drug coverage) as well. These bundled plans may have additional coverage, such as vision, hearing and dental care. Unlike Original Medicare, Medicare Advantage plans have an annual limit on out-of-pocket costs. Medicare Advantage plans are typically HMOs or PPOs and are available only in certain areas.
- Medicare Part D helps cover the cost of prescription drugs. Plans are offered by private insurers and require monthly premium that average about \$33 a month. As with Part B, there typically is a late penalty premium if you don't sign up when you are first eligible.

7. What is Medicaid and the Children's Health Insurance Program (CHIP)?

Medicaid is a federal and state health insurance program for low-income families and individuals. Medicaid has eligibility requirements that are set on a state-by-state basis, but it is primarily designed for those with low incomes and low liquid assets. It is also designed to help families and caretakers of small children in need. You can typically check if you qualify for Medicaid through Healthcare.gov or the Mississippi Division of Medicaid.

The Children's Health Insurance Program (CHIP) is a federal and state program that is similar to Medicaid, but specifically designed to cover children below the age of 18. The program is primarily aimed at children in families who have incomes too high to qualify for Medicaid, but too low to afford private health insurance. Like Medicaid, you can typically see if you qualify and apply on Healthcare.gov or the Mississippi Division of Medicaid.

Autism

1. Does MS have a law for Autism coverage?

Did You know ... Mississippi is one of 46 states with health insurance laws extending coverage for children with autism. Mississippi law requires insurance coverage for various treatments for autism and autism spectrum disorders (ASD), also known as "pervasive developmental disorders." Miss. Code Ann. § 83-9-26

2. What does the law require?

No insurer can terminate health insurance coverage or refuse to issue, amend, or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder. Health insurance plans that cover Mississippi residents must provide coverage for the screening, diagnosis, and treatment of autism and autism spectrum disorders.

3. What treatment is covered under the law?

Treatment of autism and autism spectrum disorder (ASD) can include (1) behavioral health treatment, such as applied behavior analysis (ABA) therapy, (2) pharmacy care, (3) psychiatric care, (4) psychological care, and (5) therapeutic care, such as services provided by licensed speech-language pathologists, occupational therapists, or physical therapists.

4. What is ABA Therapy?

The law defines it as "the individualized design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior." ABA therapy is a process that involves systematic interventions (like positive reinforcement) based on the principles of learning theory to improve social behaviors of individuals diagnosed with autism or ASD.

Studies have shown that many children with autism or ASD experience significant improvements in learning, reasoning, communication, and adaptability when they participate in high-quality ABA therapy programs.

5. Who must administer treatment for autism?

Treatment must be prescribed by a licensed physician, psychiatrist or psychologist and it must be provided by a physician, psychiatrist, psychologist, behavior analyst, or assistant behavior analyst who is licensed or certified by the state.

6. Are There Any Coverage Limits?

- Age: In the past, ABA therapy was limited to individuals under the age of 8. Last year, Commissioner Chaney requested that the insurance companies waive the age limitation.
- Preauthorization: Insurance companies may require preauthorization or pre-certification prior to covering these services, just as they can for medical, surgical, and mental health benefits.
- Duration: ABA therapy is limited to 25 hours/week, and no more than 10 hours/week may be for services from a licensed behavior analyst.
- Deductibles and Co-Pays: For these services, insurance companies may not have a higher deductible, co-insurance, or copayment than other physical health care services (other policy provisions may apply, such as in-network vs. out-of-network, but the amount cannot be higher just because it is treatment for ASD).
- Medical Necessity: Like treatment for other conditions, coverage for autism or ASD services is subject to a determination of medical necessity. Even though coverage cannot be denied because of an autism or ASD diagnosis, an insurance company may deny coverage for a treatment or service that it determines is not medically necessary.

7. Does the Law Apply to Every Health Insurance Plan?

Yes, except it does not apply to the following:

- ACA plans from the Marketplace
- Those plans that must have essential health benefits
- Self-funded health benefit plans under ERISA
- Where the employer pays medical claims directly, rather than have a group insurance policy for employees. Some of these plans may be handled by an insurance company, so it's important to check if your plan is self-funded and not subject to the autism coverage law.
- Medicare supplement plans
- Accident-only plans
- Plans for specified disease (other than autism or ASD)
- Hospital indemnity plans
- Disability income plans

- Long-term care plans
- Other limited benefit hospital insurance policies

8. What resources are available at the Mississippi Department of Insurance?

Autism Hotline: 1-833-488-6472

If you have questions about your coverage or if you feel your rights are being violated, please call the Hotline. Department representatives are available between the hours of 8:00 am and 5:00 pm, Monday-Friday. You can also email the Department any time at consumer@mid.ms.gov.

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